Viral Hepatitis Case Report

Acute Hepatitis B

Michigan Department of Community Health

Communicable Disease Division

Investigation Information

Investigation ID	Onset Date *mm/dd/yyyy*	Diagnosis Date *mm/dd/yyyy*	Referral Date *mm/dd/yyyy*	Case Entry Date *mm/dd/yyyy*	Case Completion Date *mm/dd/yyyy*

Investigation Status	Case Status
	○ Confirmed ○ Not a Case ○ Probable ○ Suspect ○ Unknown

Patient Status	Patient Status Date *mm/dd/yyyy*	Part of an outbreak?	Outbreak Name	Case Updated Date *mm/dd/yyyy*

Patient Information

Patient ID	First	Last	Middle

Street Address

City	County	State	Zip

Home Phone *###-###-####*	Ext.	Other Phone *###-###-####*	Ext.

Parent/Guardian (required if under 18)

First	Last	Middle

Demographics

Sex	Date of Birth *mm/dd/yyyy*	Age	Age Units
○ Male ○ Female ○ Unknown			○ Days ○ Months ○ Years

Race
(Check all that apply)
☐ Caucasian ☐ African American ☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Asian ☐ Unknown
☐ Other (Specify)

Hispanic Ethnicity	Arab Ethnicity
○ Hispanic/Latino ○ Non-Hispanic/Latino ○ Unknown	○ Arab ○ Non-Arab ○ Unknown

Worksites/School	Occupations/Grade

Referral Information

Person Providing Referral

First	Last	Phone *###-###-####*	Ext.	Email

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Referral Information cont.

Primary Physician

First	Last	Phone ###-###-####	Ext.	Email

Street Address

City	County	State	Zip

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Hospital Information

Patient Hospitalized	Hospital	Hospital City	Hospital Record No.
○ Yes ○ No ○ Unknown			

Admission Date	Discharge Date	Days Hospitalized
mm/dd/yyyy	*mm/dd/yyyy*	

Clinical Information and Patient History

Place of Birth:	Did the patient die from hepatitis?	If yes, specify the date of death:
○ USA ○ Other	○ Yes ○ No ○ Unknown	*mm/dd/yyyy*

Reason for Testing:
(Check all that apply)

- ☐ Symptoms of acute hepatitis
- ☐ Screening of asymptomatic patient with reported risk factors
- ☐ Screening of asymptomatic patient with no risk factors (e.g., patient requested)
- ☐ Prenatal screening
- ☐ Other
- ☐ Evaluation of elevated liver enzymes
- ☐ Blood / Organ donor screening
- ☐ Follow-up testing for previous marker of viral hepatitis
- ☐ Unknown

Is the patient symptomatic?	Is or was the patient jaundiced?	Is or was the patient pregnant?	If yes, specify the due or delivery date:
○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown	*mm/dd/yyyy*

Diagnosis:
(Check all that apply)

- ☐ Acute hepatitis A
- ☐ Acute hepatitis B
- ☐ Acute hepatitis C
- ☐ Acute hepatitis E
- ☐ Chronic HBV infection
- ☐ HCV infection (chronic or resolved)
- ☐ Acute non-ABCD hepatitis
- ☐ Perinatal HBV infection
- ☐ Hepatitis Delta (co- or super-infection)

Diagnostic Tests

Test Name	Result
	(P=Positive N=Negative UNK=Unknown)
Total antibody, hepatitis A virus [total anti-HAV]	
IgM antibody to hepatitis A virus [IgM anti-HAV]	
Hepatitis B surface antigen [HBsAg]	
Total antibody, hepatitis B core antigen [Total anti-HBc]	
IgM antibody, hepatitis B core antigen [IgM anti-HBc]	
Antibody to hepatitis D virus [anti-HDV]	
Antibody to hepatitis E virus [anti-HEV]	
Antibody to hepatitis C virus [anti-HCV]	
Supplemental anti-HCV assay [e.g., RIBA]	
HCV RNA [e.g., PCR]	

anti-HCV signal to cut-off ratio

Liver Enzyme Levels at Time of Diagnosis

Test Name	Result	Upper Limit Normal	Date of Result
			(mm/dd/yyyy)
ALT (SGPT)			
AST (SGOT)			

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Epidemiologic Information

Please answer the following questions for the time period 6 weeks - 6 months prior to the onset of symptoms:

Was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis B virus infection?
Yes No Unknown

If yes, type of contact
Sexual Household (Non-sexual) Other

Did the patient inject drugs not prescribed by a doctor?
Yes No Unknown

Did the patient use street drugs, but not inject?
Yes No Unknown

Did the patient undergo hemodialysis?
Yes No Unknown

Did the patient have an accidental stick or puncture with a needle or other object contaminated with blood?
Yes No Unknown

Did the patient receive blood or blood products (transfusion)?
Yes No Unknown

If yes, when?
mm/dd/yyyy

Did the patient receive any IV infusions and/or injections in the outpatient setting?
Yes No Unknown

Did the patient have other exposure to someone else's blood?
Yes No Unknown

If yes, specify:

Was the patient employed in a medical or dental field involving direct contact with human blood?
Yes No Unknown

If yes, frequency of direct blood contact:
Frequent (several times weekly) Infrequent

Was the patient employed as a public safety worker (fire fighter, law enforcement or correctional officer) having direct contact with human blood?
Yes No Unknown

If yes, frequency of direct blood contact:
Frequent (several times weekly) Infrequent

Did the patient receive a tattoo?
Yes No Unknown

If yes, where was the tattooing performed? *(Check all that apply)*
Commercial parlor/shop Correctional facility Other (specify)

Did the patient have any part of their body pierced (other than ear)?
Yes No Unknown

If yes, where was the piercing performed? *(Check all that apply)*
Commercial parlor/shop Correctional facility Other (specify)

Did the patient have dental work or oral surgery?
Yes No Unknown

Did the patient have surgery? (other than oral surgery)
Yes No Unknown

Was the patient hospitalized?
Yes No Unknown

Was the patient a resident of a long term care facility?
Yes No Unknown

Was the patient incarcerated for longer than 24 hours?
Yes No Unknown

If yes, what type of facility? *(Check all that apply)*
Jail Juvenile facility Prison

During his/her lifetime, was the patient EVER incarcerated for longer than 6 months?
Yes No Unknown

If yes, what year was the most recent incarceration?
yyyy

If yes, for how long?
(months)

Was the patient EVER treated for a sexually transmitted disease?
Yes No Unknown

If yes, in what year was the most recent treatment?
yyyy

In the 6 months prior to symptom onset, how many male sex partners did the patient have?
0 1 2-5 >5 Unknown

In the 6 months prior to symptom onset, how many female sex partners did the patient have?
0 1 2-5 >5 Unknown

Vaccine History

Did the patient ever receive hepatitis B vaccine?
Yes No Unknown

If yes, how many shots?
1 2 3 or more

In what year was the last shot received? *yyyy*

Was the patient tested for antibody to HBsAg (anti-HBs) within 1-2 months after the last dose?
Yes No Unknown

If yes, was the serum anti-HBs >= 10mIU/ml? (answer 'yes' if the laboratory result was reported as 'positive' or 'reactive')
Yes No Unknown

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Lab Results

Report Date	Test Name	Test Result	Specimen	Collection Date
(mm/dd/yyyy)				*(mm/dd/yyyy)*

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Other Information

Local 1	Local 2

Name of Person interviewed	Relationship to patient	Date of interview *mm/dd/yyyy*

Submitted by:	Date *mm/dd/yyyy*	Health Department	Phone Number *###-###-####*	Ext.

Other Information cont.

Comments or Additional Information

Case Notes

Notes